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ABSTRACT

Amounts billed for teaching physician services and paid by Medicare carriers were reviewed by the General Accounting Office (GAO) to determine whether such payments had been made only where the physicians had satisfied the requirements of the Social Security Act. Attention was focused on the requirement that teaching physicians must provide a personal and identifiable service to Medicare patients. To assess whether requirements were being met, GAO reviewed patients' medical records for randomly selected samples of Medicare patients from 10 hospitals and 9 states and additional information provided by hospitals. The review covered 8,917 services provided to 1,165 patients. GAO reviewed fee-for-service billings by teaching physicians for inpatient and outpatient services. Documentation for about half of the services, representing about 25% of the amount Medicare allowed, did not show whether the physicians had provided a personal and identifiable service. The inadequately documented services usually involved high-volume, low-cost services such as daily visits. The adequacy of Medicare documentation criteria and monitoring for compliance with Medicare requirements were addressed. Regulations being developed by the Health Care Financing Administration to implement new requirements are noted. Comments from the Social Security Administration and the Department of Health and Human Services are appended. (SW)

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United States General Accounting Office

GAO

Report to Congressional Committees

January 1986

MEDICARE

Documenting Teaching Physician Services Still a Problem

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United States
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Washington, D.C. 20548

Comptroller General
of the United States

B-221527

January 21, 1986

The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

In accordance with the requirement of section 2307(b)(2)(c) of the Deficit Reduction Act of 1984 (Public Law 98-369), we reviewed the amounts billed for teaching physician services and paid by Medicare carriers to determine whether such payments had been made only where the physicians had satisfied the requirements of section 1842(b)(7)(A)(i) of the Social Security Act.

We focused on the requirement that teaching physicians must provide a personal and identifiable service to Medicare patients and found that about half of the services reviewed were not adequately documented to show this. Our report discusses this and other issues, such as the adequacy of Medicare documentation criteria and monitoring for compliance with Medicare requirements.

In finalizing the report, we considered comments from the Department of Health and Human Services (HHS) and the hospitals we reviewed. Because of actions being taken by the Health Care Financing Administration (HCFA), the report makes no recommendations.

As arranged with your offices, copies of this report are being sent to interested congressional committees and subcommittees; the Director, Office of Management and Budget; the Secretary of HHS; the Administrator of HCFA; and other interested parties.

Charles A. Bowsher

Charles A. Bowsher
Comptroller General
of the United States

Executive Summary

Of the hospitals that participate in the Medicare program, about 28 percent are "teaching hospitals"—they operate post-graduate programs for resident physicians. The teaching physicians who instruct residents perform various functions including classroom instruction, making rounds with their students, examining patients, and discussing courses of treatment.

Medicare pays for the medical education activities of these teaching physicians, and the salaries of residents on a cost basis. Teaching physicians also treat or supervise the treatment of Medicare beneficiaries in the hospital. Medicare pays for these services on a reasonable-charge (fee-for-service) basis.

This dual method of paying teaching physicians has concerned the Congress because of the danger that Medicare will pay twice for the same service—once as a reimbursed cost and again as a fee-for-service billing. Consequently, Medicare requires teaching physicians and the hospitals where they practice to meet certain requirements designed to make double payment less likely. The Deficit Reduction Act of 1984 (Public Law 98-369, July 18, 1984) required GAO to conduct a review to determine whether these requirements were being met.

Background

In April 1969, Medicare issued guidelines as to when teaching physicians could bill on a fee-for-service basis. These guidelines permitted payment when the teaching physician provided personal and identifiable patient care services. They remain in effect and are used by the Health Care Financing Administration (HCFA), which administers the Medicare program for the Department of Health and Human Services (HHS).

Concerned about reported problems resulting from the dual method of reimbursement, the Congress in 1972 enacted legislation that required with few exceptions that teaching physicians' services be paid on a cost basis. HHS was unsuccessful in issuing implementing regulations, notwithstanding several extensions of the effective date of the act, and the legislation was repealed in 1980 except for some requirements that were retained in modified form. These new requirements provide that fee-for-service billings by teaching physicians cannot be made unless (1) the physician renders a personal and identifiable service, (2) the services provided are of the same character (comparable) as those provided to non-Medicare patients, and (3) at least 25 percent of the hospital's non-Medicare patients pay all or a substantial part of their physicians'

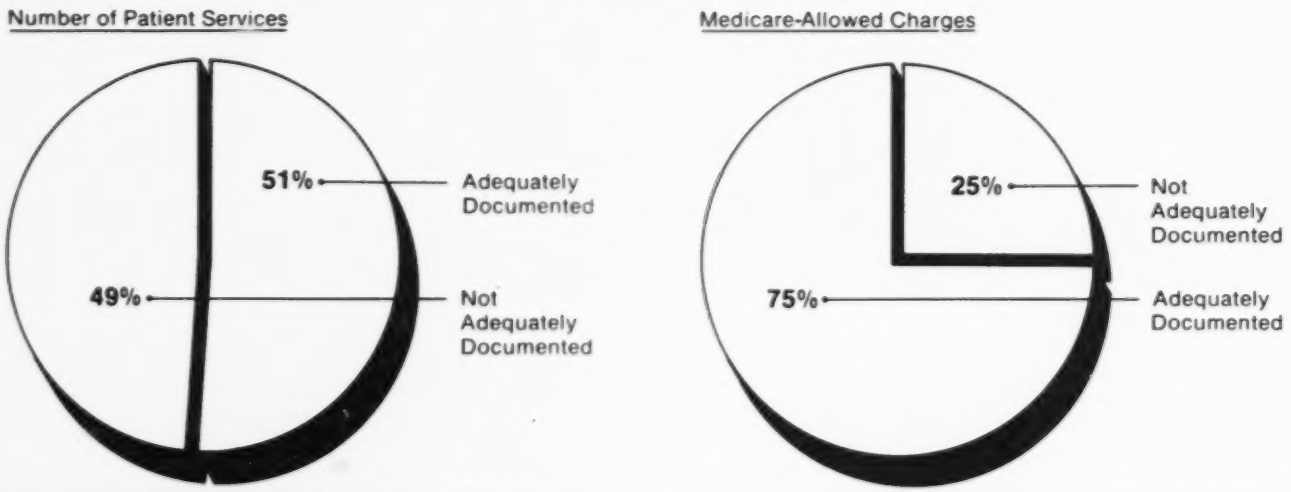
bills. The latter requirement assures that Medicare is not the only payor of teaching physicians' services in hospitals.

To assess whether these three requirements were being met, GAO reviewed patients' medical records for randomly selected samples of Medicare patients from 10 hospitals in 9 states and additional information provided by the hospitals. The states and hospitals were judgmentally selected; therefore, GAO's results cannot be projected nationwide. GAO believes, however, that the data provide a good indication of the national situation because of the geographic distribution of the areas sampled.

Results in Brief

GAO reviewed fee-for-service billings by teaching physicians for inpatient and outpatient services. Documentation for about half of the services, representing about 25 percent of the amount Medicare allowed, did not show whether the physicians had provided a personal and identifiable service (see figure 1). Consequently, for these services it could not be shown that the first of the new requirements was met. Additionally, the act's remaining two requirements were not being monitored for compliance in the six HCFA regions covered in GAO's review.

Figure 1: Documentation of Patient Services by Hospitals Reviewed



Principal Findings

Determining the allowability of teaching physicians' Medicare fee-for-service claims is difficult. It entails separating physicians' teaching

functions from patient care functions, assessing physicians' relationships with their patients, and monitoring physicians' billing practices.

Documentation Requirements Unclear

HCFA instructions governing the payment of teaching physicians do not spell out what documentation is considered appropriate to substantiate entitlement to Medicare fee-for-service reimbursement. Also, documentation requirements for the first provision vary substantially among Medicare carriers (insurance companies such as Blue Shield and Aetna that pay claims for Medicare).

Because of variations among carriers in their documentation requirements for the first provision, GAO developed criteria patterned after those followed by carriers in two HCFA regions that GAO believed were most in line with Medicare reimbursement requirements. Under these criteria, each physician service had to be documented in the hospital records in a manner that showed the teaching physician's involvement in providing the service. Hospital and medical service group officials who were briefed on GAO's review were concerned about GAO using documentation criteria different than those used by their carriers. Had GAO used each respective carrier's criteria, many of the hospitals would have had fewer services classified as inadequately documented. Nevertheless, GAO does not believe that documentation criteria that fail to establish the personal involvement of the teaching physician in the services billed are adequate to assure compliance with Medicare requirements.

Services Not Adequately Documented

GAO's review covered 8,917 services provided to 1,165 patients. A total of 4,515 (about 51 percent) were adequately documented and the remaining 4,402 services (about 49 percent) were not. The total Medicare-allowed amounts for these services was $710,820. Of this amount, $535,613 (about 75 percent) was for adequately documented services and $175,207 was for services not adequately documented.

Why the difference in the allowed amounts for the services? This came about because the inadequately documented services usually involved high-volume, low-cost services such as daily visits. Documentation for the higher value services such as surgery usually showed how teaching physicians were involved in providing the services.

For many of the services considered inadequately documented, GAO could not determine from the record whether a teaching physician or a

resident provided the services. This does not mean that teaching physicians were not involved, only that the services were not sufficiently documented in the patients' records.

Requirements Not Being Monitored

To bill Medicare on a fee-for-service basis, teaching physicians must document their patient services; the comparable-care provision must be met; and the teaching hospitals must show that the billings meet Medicare's 25-percent payment requirements. HCFA and carrier officials told GAO that the latter two requirements were not being monitored for compliance principally because HCFA had not issued implementing regulations or instructions. Hospital officials believed their hospitals met these requirements, and information they provided GAO orally supported their position. Because of the absence of specific documentation requirements and criteria necessary to assess compliance, however, GAO did not verify whether the hospitals met these requirements.

HCFA Proposes to Clarify Requirements

HCFA is in the process of developing regulations to implement these provisions; it plans to publish them for comment early in 1986. According to HCFA officials, the proposed regulations will (1) more clearly spell out documentation requirements for substantiating that teaching physicians' services meet Medicare reimbursement requirements and (2) establish guidelines for substantiating that hospitals are meeting the 25-percent payment requirements.

Thus teaching physicians and hospitals will be in a better position to know what is expected of them and understand that they will be held accountable for complying with Medicare requirements. To the extent that HCFA is successful in issuing and enforcing such regulations, the documentation problems GAO identified should be lessened.

Recommendation

Because HCFA is in the process of developing regulations to implement the new requirements, GAO is making no recommendations.

Agency Comments

HHS commented that it had carefully reviewed GAO's report and had no comments.

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Abbreviations

AAMC	Association of American Medical Colleges
DRG	Diagnosis Related Group
EKG	Electrocardiogram
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

Introduction

Under the Medicare program, beneficiaries are eligible for assistance in paying for a wide variety of health services including hospital and physician services. About 28 percent of the hospitals that participate in Medicare have programs for training physicians after medical school graduation; these hospitals are known as teaching hospitals. The physicians, known as residents, receive specialized training in a particular area of medicine (internal medicine, neurosurgery, cardiology, etc.), generally for periods of 3 to 7 years.

Residents provide services to Medicare beneficiaries at the hospital. Medicare pays for these services on a cost basis—that is, Medicare pays a portion of the physicians' salaries based on the ratio of Medicare utilization to total utilization.

Faculty members who instruct residents are known as teaching physicians. Their functions include research, classroom instruction, making rounds with residents, examining specific patients, and discussing courses of treatment. Medicare also pays part of the direct medical education activities of these teaching physicians on a cost basis.

When teaching physicians treat or supervise the treatment of Medicare beneficiaries in the hospital, Medicare pays for such services on the basis of reasonable charges or fee for service, that is, each service is billed and paid for separately. These payments to teaching physicians have been a continuing area of concern to the Congress because of the potential for incorrect payments. As a result, in section 2307 of the Deficit Reduction Act of 1984 (Public Law 98-369, July 18, 1984), the Congress required us to review Medicare payments to teaching physicians for patient care services. We were asked to determine whether such payments were made only where the physician met the requirements of section 1842(b)(7)(A)(i) of the Social Security Act, as amended.

Background

The Medicare program, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966, is a health insurance program that helps beneficiaries pay for the health services they receive. The program covers almost all persons age 65 and over and certain disabled persons. Administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS), Medicare has two parts—Hospital Insurance (part A) and Supplementary Medical Insurance (part B).

Part A covers inpatient hospital services, home health services, and certain other institutionally based services. It is financed primarily by payroll taxes on employers and employees. HCFA administers part A with the assistance of health insurance companies called intermediaries (primarily Blue Cross plans), which contract with HCFA to process and pay claims for services.

Under part A, Medicare pays hospitals a predetermined, fixed amount for Medicare inpatient hospital services. The amount paid for each patient depends on the diagnosis related group (DRG) into which the patient was classified based on the principal diagnosis of the condition or surgery for which he or she was hospitalized. DRGs constitute a patient classification system developed by Medicare to reflect differences in predicted resource use by different kinds of hospital patients. Under this system, Medicare pays a predetermined rate for all inpatient services including routine care, intensive care, and ancillary services.

Teaching hospitals usually receive higher part A Medicare payments than do nonteaching hospitals for similar cases because the prospective payment rates are adjusted upward to account for the indirect costs of medical education programs. The teaching hospitals' payments are increased 11.59 percent for each 0.1 increase in the ratio of residents to hospital beds.[1] In addition to the prospective payments, Medicare also pays teaching hospitals a portion of their direct medical education costs including the salaries of residents and teaching physicians. The portion of these direct costs paid by Medicare is determined by the hospital's ratio of Medicare utilization to total utilization.

Medicare part B, which covers physician, outpatient hospital, and various other medical and health services, is financed by enrollee premiums (currently about 25 percent) and general revenues. HCFA administers part B with the assistance of carriers—Blue Shield plans and commercial insurance companies under contract to process and pay claims.

Part B payments to physicians, including teaching physicians, for treating patients are based on "reasonable charge." Medicare pays 80 percent of the reasonable charge after the beneficiary has met an annual $75 deductible. Medicare defines reasonable charge as the lowest of

[1]If a teaching hospital's total regular Medicare part A payments equaled $1 million and its ratio of residents to beds was 0.1, Medicare would pay the hospital $1,115,900 ($1,000,000 + ($1,000,000 x .1159 x 1) = $1,115,900). If the hospital's resident to bed ratio was 0.3, Medicare would pay the hospital $1,347,700 ($1,000,000 + ($1,000,000 x .1159 x 3) = $1,347,700).

- the actual charge for the service,
- the amount the physician normally charges for the service (the customary charge), or
- an amount high enough to cover 75 percent of the customary charges for the service by all physicians in the area (the prevailing charge).

Payment for physician services is made either directly to the physician (assigned claim) or as reimbursement to the patient (unassigned claim). On assigned claims, the physician agrees to accept Medicare's reasonable charge determination as payment in full. For unassigned claims, the beneficiary is responsible for any difference between the physician's charge and Medicare's payment. Physicians who agree to accept assignment on all claims are called participating physicians.

Customary and prevailing charge levels are usually updated annually although the Congress froze payments for the period July 1984 through September 1985. The administration's fiscal year 1986 budget would have extended the freeze for another year. The Congress has not completed action on the 1986 budget but has extended fiscal year 1985 Medicare payment rates and rules until March 15, 1986. Since 1973, increases in prevailing charge levels have been limited to the increase in an economic index that measures changes in wage levels and the costs of operating a physician's office.

Requirements to Pay Teaching Physicians' Fees for Service

The original Medicare legislation did not include specific criteria for determining under what circumstances teaching physicians could bill separately for patient care on a fee-for-service basis but left this area for implementing regulations. Medicare's implementing regulations permitted fee-for-service payment when the teaching physician provided personal and identifiable direction of the patient's care, including personal supervision of major surgical or other complex procedures.

In April 1969, Medicare issued guidelines for determining when teaching physicians met the personal and identifiable service criteria. These guidelines, included in Intermediary Letter Number 372 (IL-372—see app. I), list requirements to be met before teaching physicians can bill for patient care services provided in a teaching setting. IL-372 was supplemented in January 1970 by IL-70-2, which addresses questions that had arisen about the implementation of IL-372. These two sets of guidelines have remained in effect to date and provide the basis for determining the allowability of fee-for-service billings by teaching physicians.

GAO previously reviewed part B claims for services provided by teaching physicians at six hospitals and reported the results in November 1971.[2] We found that interns[3] and residents had provided 67 percent of the services that teaching physicians had billed for, according to hospitals' medical records. Because the services of interns and residents were paid on a cost basis under part A and teaching physicians were paid on a fee-for-service basis under part B, in effect duplicate payments had been made.

The Congress attempted to address this problem by revising the method by which teaching physicians were paid for patient care services. Section 227 of the Social Security Amendments of 1972 (Public Law 92-603, Oct. 30, 1972) required, with a few exceptions, that Medicare part A pay teaching physician services on a reasonable-cost basis. HHS was unsuccessful in issuing implementing regulations for this change, and the Congress delayed the effective date of section 227 several times. The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Dec. 5, 1980) repealed section 227 of the 1972 amendments while retaining some of its features in modified form. The requirements of the 1980 law are included in section 1842(b)(7)(A)(i) of the Social Security Act, which provides that part B payments for teaching physicians' services cannot be made unless

- the physician renders sufficient personal and identifiable services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought,
- the services provided Medicare beneficiaries are of the same character as those furnished to patients not entitled to Medicare benefits, and
- at least 25 percent of the hospital's patients who were not entitled to Medicare benefits and who were furnished services as described above paid for all or a substantial part of the charges imposed for such services.

HCFA has not yet issued regulations implementing these provisions. The conference committee report on the 1980 legislation endorsed the IL-372 requirements that define the condition under which a teaching physician may bill for medical services on a fee-for-service basis, and HCFA

[2]Problems in Paying for Services of Supervisory and Teaching Physicians in Hospitals Under Medicare, B-164031(4), Nov. 17, 1971.

[3]According to information obtained from the Association of American Medical Colleges (AAMC), the term "intern" is no longer being used. The one year of internship previously required is now the first year of residency.

uses these guidelines as its primary instructions for enforcing the section's first provision.

How Residents and Teaching Physicians Were Paid

Typically, full-time teaching physicians are salaried and part of their salaries is paid out of revenues generated through their patient care activities. Residents also are salaried, and the Medicare portion of their salaries is paid out of part A on a cost basis. Generally Medicare does not allow residents to bill for direct patient care services.[4] Details of the arrangements at hospitals we reviewed follow.

Payments to Teaching Physicians

The teaching physicians at the 10 hospitals covered by our review had various financial arrangements for their teaching, administrative, and patient care services. Depending on ownership and control of the hospital, the full-time teaching physicians were either employees of the state, medical school, or hospital, or were members of medical service groups that provided patient care services to patients at the hospital. In some cases, teaching physicians were both employees and members of a medical service group. These arrangements ranged from full-time salaried to part-time unsalaried positions. In some instances, salaries covered all services including patient care, while for others salaries covered only teaching and administrative services and were augmented by patient care income. Part-time teaching physicians were generally paid from patient care fees, either through a medical service group or by direct billings. Some also received a salary.

As to salary amounts, five hospitals gave us either an overall range for all their full-time teaching physicians or ranges for the physicians in each medical department. (The other five gave us no salary ranges.) For the hospitals that provided such information, the salaries ranged from $23,640 to $38,100 a year for beginning instructors, and from $147,120 to $210,000 for department heads. The higher salaries generally represented the maximum compensation teaching physicians could earn during the year, while the lower salaries could be supplemented by patient care income and/or research funds.

[4]In some instances, residents' patient care services can be billed for under part B, such as when they provide services as practicing physicians outside the teaching setting—for example, when they work on their own time in a hospital outpatient clinic.

How the teaching physicians were employed and patient care billings and payments were the major differences among the hospitals reviewed, i.e.:

- At two of the hospitals, the full-time teaching physicians received an annual salary for all their services—administrative, research, teaching, and patient care. At one hospital, the physicians were employed by the hospital, while at the other they worked through three medical service groups, which paid them for their services. The hospital or groups did all billings for patient care, using either individual physician or group provider numbers, and collected all revenues from patient care.
- At the other eight hospitals, the teaching physicians were employed by either the state, school, or hospital and paid an annual salary for their teaching, research, and administrative duties. For their patient care services, they received a salary supplement, usually through a medical service group. Generally, billings for patient care services were done by the medical service group for the physicians.

The total annual compensation each physician could receive was negotiated yearly at most of the hospitals. Some of the patient care revenues generated by the teaching physicians were shared with the medical school and various hospital departments to support teaching, research, and patient care activities.

Typically the revenues that teaching physicians generated from Medicare part B billings (as well as revenues generated from their non-Medicare patients) went into a pool maintained either by the hospital or the physician's medical practice groups. The physicians were reimbursed from this pool either indirectly as part of their salary or directly as a supplement to their salary. Because teaching physicians most often billed Medicare using their group's provider number, the carriers could not give us specific information on Medicare part B reimbursement for individual physicians. However, we obtained from the hospitals or groups the names of full-time teaching physicians, identified by group or individual provider numbers. This information was then used to obtain from the carriers total Medicare part B reimbursements made in 1984 to the identified physicians or groups.

The reimbursement information we obtained from the carriers is summarized by hospital in table 1.1. To the extent that the data were made available to us, we also included the number of full-time teaching physicians who could bill under the listed provider numbers and the percentage of Medicare patients treated by the hospital during the year.

Table 1.1: Medicare Part B Reimbursements for Full-Time Teaching Physicians at Hospitals Reviewed

Hospital	Total part B reimbursement in 1984 (millions)	No. of full-time teaching physicians	Percentage of hospital's patients covered by Medicare
A	$ 4.42	269	26.4
B	4.73	344[a]	10.8
C	2.56	344[a]	6.2
D	15.85	282	35.7
E	10.27	525	[d]
F	4.73	330	12.8[c]
G	7.45	361	18.8
H	6.23	182[b]	28.7
I	1.93	267	21.0
J	[d]	[d]	[d]

[a]Includes some part-time teaching physicians.

[b]Includes 172 full-time and 10 part-time physicians.

[c]This number represents the percentage of Medicare billings to total billings made by the physicians' medical service group, rather than percentage of patients.

[d]Not provided.

Payments for Residents

Residents at the 10 hospitals usually were employed by the hospitals and reimbursed for their services on the basis of an annual salary, which varied by year of training. Resident programs varied in length depending on the specialties involved and could last as long as 7 years. Residents' duties and responsibilities also varied by hospital department, and they generally worked with or under the direction and supervision of a teaching physician. Most programs were designed in such a way that residents' patient care responsibilities and salaries progressively increased as they advanced through the program.

First year residents' salaries ranged from about $18,260 to $23,000, while those in the last year ranged from about $22,460 to $31,000. As previously stated, part of these salaries are reimbursed by Medicare based on the ratio of Medicare utilization to total utilization.

Objectives, Scope, and Methodology

The objectives of our work were to

- determine whether Medicare payments for services provided by teaching physicians were made in accordance with section 1842(b)(7)(A)(i) of the Social Security Act, and
- develop information on guidelines and instructions issued to implement Medicare reimbursement requirements for teaching physicians' services and the enforcement of these instructions and guidelines.

Our fieldwork was done from November 1984 through August 1985 at 10 teaching hospitals,[5] at HCFA headquarters and 6 of its 10 regional offices, and at the 9 Medicare carriers that pay claims for services provided by physicians at the hospitals. The states and hospitals were judgmentally selected; therefore, our results cannot be projected nationwide. We believe, however, that our data provide a good indicator of the national situation because of the geographic distribution of the areas sampled. In selecting the hospitals, we looked for those with large numbers of residents in their medical education programs, which generally meant teaching hospitals with large numbers of beds (see table 1.2). Five of the 10 hospitals were located along the eastern seaboard because of the large number of medical schools in this area.

Table 1.2: Relative Sizes of Hospitals Reviewed: Numbers of Beds and Residents

Hospital	Numbers of Beds	Residents
A	452	349
B	937	567
C	540	253
D	980	432
E	1,008	780
F	1,050	545
G	735	471
H	616	334
I	509	227
J	366	144

The distribution of hospitals by HCFA region, carrier, and state appears in table 1.3.

[5]One more hospital was covered by our review, but, because of legal delays our work at that location has not been completed. (See p. 16 for more information.)

Table 1.3: Distribution of Hospitals Reviewed by HCFA Region, Medicare Carrier, and State

HCFA region	Medicare carrier	State	No. of hospitals
I	Blue Shield of Massachusetts	Massachusetts	1
III	Pennsylvania Blue Shield	Pennsylvania	1
	Blue Cross/Blue Shield of Maryland	Maryland	1
	Travelers Insurance Companies	Virginia	1
IV	The Prudential Insurance Company of America	North Carolina	1
V	Blue Cross and Blue Shield of Michigan	Michigan	1
VI	Group Medical and Surgical Service	Texas	2
X	Aetna Life and Casualty	Oregon	1
	Washington Physicians Service	Washington	1

For another Michigan hospital, pertinent medical records ultimately had to be obtained by subpoena. Because of the delays associated with the hospital's refusal to volunteer the records, we could not complete work at that location in time for inclusion in this report. Information on the results of that work will be provided separately.

Our review covered inpatient and outpatient physicians' services provided to Medicare beneficiaries during the latter part of 1984. Using data provided by the hospitals, we randomly selected samples of Medicare patients discharged from the hospitals or treated through their outpatient clinics during the randomly selected week of November 4-10, 1984.

For each of the discharged patients, except those with extended periods of hospitalization, we reviewed all physicians' services provided during the applicable hospital stay. For the patients with extended periods of hospitalization, our review was limited to the services provided during the period from October 1, 1984, through the day of discharge. For patients treated through the outpatient clinics, we covered only the services provided by physicians on the day the patient visited the clinic. We obtained payment data from the carriers to determine what services were allowed and paid for by Medicare. The hospital identified teaching physicians and residents for us.

Time did not allow us to review outpatient services for Medicare patients at two of the hospitals as indicated in table 1.4. At two other

hospitals, time permitted us to review medical records for a limited sample of outpatients. Table 1.4 shows, for each hospital, the number of Medicare patients discharged, the number receiving outpatient care during the sample week, and the number included in each sample.

Table 1.4: Numbers and Types of Patients Included in Our Sample by Hospital

	No. of patients			
	Discharged from the hospital		Receiving outpatient care	
Hospital	Medicare patients	GAO sample	Medicare patients	GAO sample
A	82	50	201	80
B	79	50	1,150	87
C	23	20	732	90
D	237	78	2,110	79
E	153	73	847	138
F	95	57	324	105
G	86	55	[a]	0
H	105	63	[a]	0
I	59	54	666	19[b]
J	54	48	575	19[b]
Totals	**973**	**548**	**6,605**	**617**

[a]Time did not permit a review of outpatient services at these two hospitals.

[b]Medical records reviewed for limited sample of patients.

We examined pertinent hospital medical records for all services provided by teaching physicians and reimbursed by Medicare to determine whether the physicians' involvement with the services was adequately documented in the records. This gave us a basis for determining if the payments were made in accordance with Medicare requirements.

Early in the review, we were advised by HCFA and carrier officials that the second and third requirements of section 1842(b)(7)(A)(i) were not being monitored for compliance, primarily because HCFA had not yet issued implementing regulations. Consequently, our efforts were concentrated on the first requirement—that the teaching physician render sufficient personal and identifiable services to exercise full personal control over the management of that portion of the care for which payment is sought. However, we asked the hospitals to provide us information showing how they determined compliance with the second and third requirements.

In addressing the first requirement, our approach was to determine whether the teaching physician had adequately documented in the patient's medical records the services billed to and paid by Medicare. Essentially, IL-372 requires that physicians, to bill fee-for-service for service provided in a teaching setting, must establish that they were functioning either as attending physicians or alternately that they personally performed the services being billed to Medicare.

To establish that a physician is functioning as an attending physician, IL-372 requires that the patient's hospital records show the physician had a personal and continuing relationship with the patient. Teaching physicians usually practiced in a group, where more than one physician in the group sees the patient. Thus we could not determine, except in the case of surgery or anesthesiology, whether documentation in the patients' records showed a physician's personal and continuing involvement in providing or directly supervising the services provided. Consequently, in these cases, we assumed the attending physician requirement was met and focused on determining whether the billing physicians rendered sufficient personal and identifiable services to exercise full personal control over the management of that portion of the case for which payment was sought. The criteria used to make these determinations are discussed in detail in chapter 2. We did not verify whether the documented services were (1) actually provided, (2) medically necessary, or (3) properly paid by the carriers.

We discussed with carrier and HCFA officials the adequacy of Medicare guidelines and instructions, particularly those relating to documentation requirements for services provided by teaching physicians. We also discussed enforcement and surveillance activities by the carriers and HCFA.

Our review was made in accordance with generally accepted government auditing standards.

Physicians' Services Not Adequately Documented

Our review of hospital medical records for physician services billed by teaching physicians and paid by Medicare showed that documentation problems existed. Teaching physician billings for inpatient and outpatient services provided to Medicare beneficiaries at the 10 hospitals reviewed revealed inadequate documentation in about 49 percent of the services reviewed, representing about 25 percent of the allowed charges. That is, the patients' records did not show how or to what extent teaching physicians were involved in providing the services.

The fact that we considered a service not adequately documented should not, however, be interpreted to mean that the teaching physician was not involved in providing the service. As used in this report, inadequately documented services means that, from the records reviewed and information provided by the hospitals or medical service groups, we could not determine under what circumstances or to what extent the teaching physician was involved in providing the service Medicare paid for.

HCFA's instructions did not explicitly define what constituted appropriate and adequate documentation to support teaching physicians' claims for reimbursement. Furthermore, the documentation criteria the carriers used varied. Consequently, we developed criteria patterned after that followed by carriers in two HCFA regions which, in our judgment, were most in line with the Medicare reimbursement requirement that teaching physicians, to be reimbursed, must provide personal and identifiable services to program beneficiaries. Therefore, our criteria required documentation in a patient's medical records that the teaching physician either personally provided the service or was present when the service was provided by a resident.

In addition to documenting their services, for teaching physicians to bill for Medicare services on a fee-for-service basis, the teaching hospital should be able to demonstrate that it meets the comparable services and 25 percent payment requirements of 1842(b)(7)(A)(i). These provisions of the act do not specify how, or if, these requirements should be documented, and as of December 1985, HCFA had not issued implementing regulations or instructions. Principally because of this, in the six HCFA regions covered by our review, these provisions were not being monitored for compliance. Although hospital officials believed they were meeting these requirements, we did not verify this because of the absence of specific documentation requirements and criteria necessary to assess compliance.

HCFA Documentation Requirements Not Clearly Defined

HCFA's instructions governing fee-for-service payment to teaching physicians are not explicit as to what documentation is considered appropriate to substantiate entitlement to such payments. The instructions are contained in IL-372, IL-70-2, and the Carriers Manual.

With teaching physicians, documentation showing how they were involved with the services billed for is particularly important because they are practicing physicians who provide direct care to patients in addition to their role as administrators and teachers. Both services related to the physicians' teaching and administrative duties and those performed solely by residents supervised by teaching physicians are paid on a reasonable cost, proportionate share basis under part A. Consequently, teaching physicians are entitled to be reimbursed by Medicare on a fee-for-service basis under part B only when they provide direct patient care services or directly supervise such care provided by residents.

The key elements of IL-372 relating to documentation for part B payment are that (1) an attending physician relationship must be established between the teaching physician and the patient, and (2) the services provided to establish this relationship must be demonstrated in part by notes and orders in the patient's records. If the attending physician relationship cannot be established, Medicare will reimburse only the services personally provided by the physician and substantiated by "appropriate and adequate" documentation. However, we do not believe that HCFA adequately defines in these instructions what constitutes "appropriate and adequate" documentation or notes and orders necessary to determine whether these conditions are being met.

In January 1970, IL-372 was supplemented by IL-70-2, which summarizes major questions on the implementation of IL-372 raised by carriers, intermediaries, and others affected by it. IL-70-2 also discusses the basic policies applicable in paying for the services of teaching physicians and various situations that must be documented. It is not explicit, however, as to what types of notations or remarks should be included in the patient records to substantiate that billed services meet Medicare criteria.

HCFA's Carriers Manual (section 8201) essentially summarizes the attending physician requirements of IL-372. As evidence that a covered service was provided, the manual says, the medical record must contain signed notes by the physician showing that he/she personally (1) reviewed the patient's medical history, (2) gave a physical examination,

(3) confirmed or revised the diagnosis, (4) visited the patient during the more critical periods of illness, and (5) discharged the patient. For other individual instances of service billed, the manual states that notes by residents or nurses indicating that the physician was physically present when the service was rendered constitute sufficient documentation of the physician's involvement to establish the attending physician relationship. Absent such notes, the manual does not define when and how specific medical procedures or services should be documented to establish entitlement for Medicare reimbursement.

HCFA officials told us that responsibility for implementing IL-372 was generally delegated to the carriers. In this respect, IL-372 states that the carrier is expected to make appropriate checks of patient records to verify that the services billed meet appropriate criteria. Some regional office officials said that HCFA's instructions were not clear enough and allowed the carriers too much discretion in determining what was acceptable documentation to support teaching physicians' fee-for-service billings. Because of this discretion, we found variations among carriers in the documentation requirements established and followed.

Documentation Requirements Varied

Documentation requirements varied among the nine carriers that paid Medicare part B claims for services at the 10 hospitals we reviewed. The carriers are responsible for paying claims submitted for teaching physicians' services and periodically auditing those claims to assure adequate documentation in the patients' records to substantiate entitlement to Medicare reimbursement. Of the nine carriers, three had written instructions supplementing HCFA's. The remaining six followed a variety of rules and practices that evolved as a result of (1) their past reviews and audits of physician billings, (2) discussions with HCFA regional office officials who monitor their performance, or (3) discussions with physicians or physician groups practicing at the hospitals under their jurisdiction.

The carriers' criteria for documentation of services performed ranged from requiring periodic countersignatures by teaching physicians to showing the teaching physicians' presence and involvement in each service provided and billed for. With countersignatures alone, it was not possible to ascertain whether the physician was directly involved in the service or was reviewing the residents' notes as part of his/her teaching responsibilities. Reviewing resident notes alone is generally considered a teaching function reimbursable under part A and is not sufficient to establish entitlement to fee-for-service reimbursement under part B.

Examples of the variations in carrier documentation requirements for specific services are discussed in the following sections.

Physicians' Daily Care or Visits

Documentation requirements for daily care or visits at the hospitals reviewed ranged from notations in the records by the physicians for each visit to notations every 2 or 3 days. For example:

- Five carriers required teaching physicians to document each daily visit for which a billing was made. The others required only some notation in the patients' records by the physician every 2 or 3 days to show that the patient was seen, even though Medicare was billed for a daily visit for every day the patient was hospitalized.
- Four carriers accepted residents' or nurses' notes countersigned by a physician as sufficient evidence that the teaching physician participated in providing the patient care billed for.
- Five carriers did not accept a physician's countersignature on residents' and/or nurses' notes unless the notes indicated that the physician had actually seen the patient or was present when the patient was visited by a resident.

Ancillary Services

Ancillary services, such as X-rays, electrocardiograms (EKGs), and laboratory tests were some of the services most commonly provided to the patients included in our review. The teaching physician's charge for these services usually covered reviewing and interpreting X-rays, EKGs, or test results. The interpretive reports were generally typed or computer-generated and included the names of the teaching physician and/or residents. The carriers' criteria for acceptability of these documents varied as follows:

- Seven carriers accepted reports signed or initialed by a teaching physician as adequate documentation, even though the report may have been prepared by a resident and did not indicate involvement by a teaching physician. The other two required that the extent of the teaching physicians' involvement be shown in the report.
- Two carriers accepted stamped signatures as evidence that the teaching physician was involved, even though the report did not indicate the nature or extent of the involvement.
- Six accepted as sufficient evidence computer-generated reports that identified the teaching physicians.

Surgical Procedures

Because every hospital required that surgical procedures including anesthesiology be documented, such procedures were generally better documented than were ancillary services or daily visits. However, there were variations in the information required to be included in reports as illustrated by the following:

- Eight carriers accepted a written report prepared either by the performing physician, a resident, or operating room nurse as adequate evidence, provided the report showed that the teaching physician was present during the operation. The ninth carrier required that the reports show how and to what extent the teaching physician was involved in performing the procedure.
- Five carriers accepted surgery reports as adequate documentation for all services provided when a global fee was charged for the surgery. Such fees usually cover both pre- and postoperative care as well as the surgery. Three carriers required additional documentation to show that the billing physician was involved in providing some of the pre- and postoperative care included as part of the fee, but the extent of involvement required to be shown varied.

Documentation Criteria Used by GAO

Because HCFA's documentation requirements were not explicit and there were variations among carriers in their respective requirements, we developed our own criteria for assessing whether teaching physicians adequately documented the services they billed to Medicare. We patterned our criteria after those followed by carriers in two HCFA regions that we judged to be most reliable in assuring compliance with Medicare requirements, i.e., to be reimbursed on a fee-for-service basis, teaching physicians must document that they provided personal and identifiable services to Medicare beneficiaries. In line with this, the two regions required that each physician service be documented in the hospital records in a manner showing how the teaching physician was involved in providing the service.

Using these criteria, we accepted as adequate any documentation such as written comments, notes, or reports in the patients' medical records which showed that the teaching physician either personally provided the service or was present when a resident was also involved. Physicians' countersignatures on notes or reports prepared by residents or nurses were not accepted unless the notes, reports, or other evidence in the patients' records showed that the physician was involved or present when the service was provided.

Typed or computer-generated reports such as those often used for X-rays, EKGs, and laboratory tests signed or initialed by a teaching physician were accepted if there was no indication in the reports that a resident was involved. If a resident provided the service, we looked for some indication that the teaching physician was present or personally involved in providing the service.

Some Physicians' Services Not Adequately Documented

Using our criteria, we determined that about 49 percent of the 8,917 services we reviewed, representing about 25 percent of the allowed charges, were not adequately documented. As a result, under our documentation criteria it could not be shown that the requirements of section 1842(b)(7)(A)(i) had been met for these services.

The numbers of patients, services, and Medicare amounts allowed for both inpatient and outpatient services covered by our review at each of the teaching hospitals we reviewed are shown in table 2.1. About 90 percent of the services reviewed were inpatient hospital services; the other 10 percent were outpatient care services.

Table 2.1: Number of Patients, Services, and Medicare-Allowed Amounts Reviewed by GAO

Hospital	No. of patients in GAO sample	No. of services reviewed[a]	Medicare amounts allowed[a]
A	130	896	$ 50,445
B	137	580	42,489
C	110	309	14,853
D	157	1,273	87,856
E	211	1,378	114,389
F	162	945	79,234
G	55	745	51,510
H	63	1,392	112,743
I	73	546	67,981
J	67	853	89,320
Totals	**1,165**	**8,917**	**$710,820**

[a]Does not include numbers or amounts for services billed but disallowed by the Medicare carriers.

As shown in table 2.1, our review covered 8,917 services provided to 1,165 patients. A total of 4,515 services (about 51 percent) were considered adequately documented; the remaining 4,402 (about 49 percent) were not. The total Medicare amounts allowed for all these services was $710,820. Of this amount, $535,613 (about 75 percent) was for the services considered adequately documented, and $175,207 was for those

considered not adequately documented. For each hospital reviewed, table 2.2 compares services considered adequately documented and those considered not adequately documented by the number, percentages of services, and Medicare-allowed amounts.

Table 2.2: Comparison Between Services Considered Adequately and Not Adequately Documented by Hospital

	Adequately documented			Not adequately documented		
Hospitals	No. of services	Percentage of services	Percentage of amounts allowed	No. of services	Percentage of services	Percentage of amounts allowed
A	297	33	55	599	67	45
B	318	55	74	262	45	26
C	92	30	57	217	70	43
D	482	38	64	791	62	36
E	792	57	89	586	43	11
F	625	66	92	320	34	8
G	343	46	66	402	54	34
H	900	65	78	492	35	22
I	252	46	58	294	54	42
J	414	49	86	439	51	14
Totals	**4,515**	**51**	**75**	**4,402**	**49**	**25**

Why the significant difference between allowed amounts for services considered adequately documented and those that were not? They differed because the inadequately documented services usually involved high-volume, low-cost services such as daily visits and reading and interpreting ancillary services reports such as X-rays, EKGs, and test results. Because of the stricter hospital documentation requirements for operating room procedures, documentation for the higher value services such as surgery or anesthesiology usually showed that a teaching physician either provided the service or was present when it was provided. This evidence was accepted as adequate even though the documentation did not show how or to what extent the teaching physician was personally involved in providing the service.

For about one-third of the services where adequate documentation was lacking, we could not determine from the records whether the service had been provided by a resident or a teaching physician. About 38 percent of the services were provided by residents; for these, we could not find sufficient evidence of the teaching physicians' involvement. Our reasons for questioning the adequacy of documentation for the services and their incidence (totaling 100 percent) were:

- Could not determine whether a teaching physician or resident provided the service—documentation showed either could have been involved (31 percent);
- Could not find sufficient evidence that the teaching physician provided a personal and identifiable service (25 percent);
- Documentation showed that the service was provided by a resident, and the record was initialed or signed by a teaching physician with no other evidence of the physician's involvement (22 percent);
- Service provided by a resident, record not initialed or signed by a teaching physician, and no other evidence of involvement by a teaching physician (16 percent); and
- Other reasons, including missing records, no evidence in record that a service was provided, or records could not be read (6 percent).

We discussed each service identified as not being adequately documented with officials from either the hospital or the physicians' medical practice groups and gave them an opportunity to find missing documents or explain why existing documentation should be considered adequate. We considered the service to be inadequately documented for Medicare reimbursement only when (1) the missing records or documents were not found, (2) the additional information provided was not sufficient, or (3) the records could not be read by us or hospital officials.

Because we considered a service not adequately documented for Medicare reimbursement purposes does not mean that the service was not provided or that a teaching physician was not involved. It means only that the medical records made available and reviewed by us did not adequately show how or to what extent teaching physicians were involved in the service Medicare paid for.

Two Legislative Requirements Not Being Monitored

In addition to documenting their services, for teaching physicians to bill for Medicare services on a fee-for-service basis, the comparability of care provision must be met and the teaching hospitals must meet the 25-percent payment requirements of 1842(b)(7)(A)(i). HCFA and carrier officials told us that these two requirements were not being monitored for compliance principally because HCFA had not issued implementing regulations nor provided instructions to the regions or carriers on how to monitor for compliance.

These two provisions were added by the Omnibus Reconciliation Act of 1980 to address issues raised in a 1970 Senate Finance Committee staff report on the need to modify the way Medicare reimbursed teaching

physicians. The issues related to Medicare's obligations to reimburse teaching physicians on a fee-for-service basis.

The first issue, involving comparability of care, concerned perceived differences in doctor-patient relationships between teaching physicians and their private patients, and those physicians and their institutional patients. Private patients are those whom the physicians treat through their private practices and personally admit to the hospital. In these instances, the relationship between doctor and patient is one-to-one with each recognizing the obligations of the other. In contrast, institutional patients are those usually referred to the hospital by a physician who is not a member of the hospital's staff or patients who present themselves at the hospital and are admitted by a member of the hospital's house staff. These patients are usually assigned to a teaching physician.

Recognizing the possible differences in physicians' involvement between these two types of patients, the Congress in enacting the Social Security Amendments of 1972 modified the method of reimbursing teaching physicians by allowing them to continue billing fee-for-service for their private patients but not for institutional patients. Care for institutional patients was to be paid on a reasonable cost basis (e.g., as part of teaching physicians' salaries) from Medicare, part A. As discussed in chapter 1 (see p. 11), regulations implementing these amendments were never issued. The effective date of the legislation was postponed several times, and the amendments were repealed in 1980.

The second issue involved the requirement that 25 percent of a hospital's non-Medicare patients who receive services from teaching physicians be billed and pay for all or a substantial part of the charges for such services. There were concerns that third-party payers other than Medicare may not have been customarily paying teaching physicians on a fee-for-service basis for supervisory services rendered in teaching hospitals. In this respect, the Committee report stated:

"In those cases where payment was made on a fee-for-service basis by a third-party insurer, it was made on a limited basis and usually only if: (a) other patients were similarly charged; (b) a charge was made and payment customarily expected from insured and non-insured patients alike; (c) the service billed for was clearly described and personally provided; and (d) there was a legal obligation on the part of the patient to pay such a charge."

Consequently, the Social Security Amendments of 1972 contained a provision similar to that now in effect (although the 1972 amendment was

more stringent as it required that 50 percent of patients' services be billed and subsequently paid for).

Given the absence of implementing regulations, HCFA and carrier officials told us that they have not performed reviews to determine whether these two requirements are being met. Furthermore, HCFA officials in some of the regions covered by our review generally believed that the two provisions were not enforceable. Essentially both provisions would require reviewing private patient records, thus raising privacy issues that we believe would be difficult to resolve. Additionally, we believe that assessing comparability of care in and of itself is methodologically complex. Consequently, in the absence of implementing regulations clearly specifying criteria for measuring comparability, this provision would be difficult to enforce.

Because these two provisions were not being monitored for compliance by HCFA or the carriers, we asked hospital officials to give us information showing whether they were being met. The officials were generally of the opinion that both were, because

- physicians were required to provide equal care for all patients,
- patients were not identified by source of payment so attending physicians usually did not know at the time services were provided who would pay for them,
- Medicare beneficiaries accounted for a relatively small percentage of the patients treated at their hospitals—usually less than 25 percent, and
- the hospitals' Medicare revenues accounted for only a small part of the hospitals' total revenues.

Information provided by eight hospitals confirmed that Medicare patients typically represented a small percentage of their total patient load. Two hospitals did not provide this information. At the hospitals reviewed, the percentage of patients treated during 1984 who were covered by Medicare ranged from 6 to 36 percent with only one hospital having a Medicare patient population higher than 30 percent. Although the information provided to us orally indicated the hospitals were complying with these provisions, absent specific documentation requirements and criteria, we did not verify whether these two requirements were being met.

HCFA Developing Regulations and Increasing Enforcement Efforts

Although section 1842(b)(7)(A)(i) was enacted in 1980, HCFA has not issued implementing regulations. As of December 1985, however, a HCFA official told us the agency had prepared draft regulations that were being reviewed and revised internally prior to being forwarded to the Secretary of HHS for review and approval. Plans were to publish the proposed regulations for public comment early in 1986.

Among other things, the proposed regulations will cover most of the requirements of section 1842(b)(7)(A)(i). According to HCFA officials, the regulations will

- clarify documentation requirements for substantiating that teaching physicians' services meet Medicare reimbursement requirements and
- establish documentation requirements for substantiating that hospitals are meeting the 25-percent payment requirement.

In addition, HCFA and carrier officials told us that in 1983 the agency started to emphasize to carriers the need to perform IL-372 reviews. Prior to that time, carriers and HCFA regional officials told us, there was little emphasis on these reviews. During our review, we found that some carriers were generally giving more audit attention to reimbursements for physicians' services provided in a teaching setting, usually through postpayment reviews, than they were prior to 1983. However, it was too early to assess the results of this increased audit activity based on the 1984 services reviewed.

Views of Hospital and Medical Service Group Officials

At the conclusion of our review at each hospital, we briefed either hospital or medical service group officials on the results of our review of hospital patient records. The most consistent concerns these officials raised were with the criteria we used and how the results of our documentation findings ultimately would be interpreted.

These officials were critical of our use of criteria different than those used by the carriers who processed their claims. As we discussed previously, we developed our own criteria because of the absence of explicit HCFA criteria and the variances in criteria being used by the nine carriers included in our review. We recognize that our documentation criteria were more stringent than those used by most carriers, because we required more evidence showing the involvement of the teaching physicians in the services they billed to Medicare than most of the carriers would have required. Had we used each respective carrier's criteria,

many of the hospitals would have had fewer services classified as inadequately documented. We did not, however, quantify what these differences would have been. But we do not believe that documentation criteria that fail to establish the personal involvement of the teaching physician in the services billed to Medicare are adequate to assure compliance with the requirements of the Medicare law.

These officials were also concerned that the reporting of undocumented services would be interpreted to mean the services were either not provided or the teaching physicians were not involved with the services. We believe we have adequately recognized in this report that our findings relating to inadequately documented services should not be interpreted to mean that the service was not provided or that a teaching physician was not involved—only that we could not determine from the records under what circumstances or to what extent the teaching physician was involved.

Conclusions

Our review of patient medical records indicated that under our criteria about 49 percent of the services representing about 25 percent of allowed charges were not adequately documented. Therefore, under these criteria it could not be shown that the teaching physicians who billed Medicare for these services had met reimbursement requirements. Additionally, because of the absence of documentation requirements and criteria for assessing compliance, we did not verify whether the 10 hospitals reviewed met the comparability of care and 25-percent payment requirements of the law. Compliance with these provisions is a prerequisite for hospitals to establish the allowability of their teaching physicians' fee-for-service billings to Medicare.

Under any set of regulations or instructions, determining the allowability of teaching physicians' Medicare fee-for-service claims is difficult. It entails separating physicians' teaching and administrative functions from their patient care functions; assessing the physicians' relationships with their patients to determine if "attending physician" requirements are met and if they treat their Medicare and non-Medicare patients the same way; and monitoring distinctions in physicians' billing practices between Medicare and non-Medicare patients. There exists the potential for (1) inappropriate payments for services that other insurers or patients do not pay for or (2) paying for some services twice—once through Medicare part A and again through Medicare part B. Recognizing these difficulties, the Congress in 1972 amended the law generally

to reimburse teaching physicians on a reasonable-cost basis. Because of problems underlying implementation, the law was repealed in 1980.

As long as the fee-for-service method remains in effect, HCFA needs to establish and enforce explicit documentation requirements so that teaching physicians and hospitals know what is expected of them and understand that they are to be held accountable for not complying with Medicare requirements. We believe HCFA's current requirements for documenting physicians' fee-for-service billings are not explicit enough and the requirements being enforced vary substantially among carriers.

HCFA is in the process of developing regulations that officials told us would clarify and establish the requirements teaching physicians and hospitals must meet to continue billing Medicare on a fee-for-service basis. To the extent that HCFA is successful in issuing and implementing such regulations and maintains its current emphasis on carrier enforcement, the documentation problems we identified should be lessened.

Agency Comments

HHS stated that it had carefully reviewed our report and had no comments. (See app. II.)

Social Security Administration, Bureau of Health Insurance: Intermediary Letter No. 372, April 1969

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

MI:PS:H

April 1969

BUREAU OF HEALTH INSURANCE
INTERMEDIARY LETTER NO. 372

SUBJECT: Part B payments for services of supervising physicians in a teaching setting

From questions which have been raised and from our onsite reviews, there appears to be a serious need to obtain a better and more uniform understanding among carriers, providers, and physicians of the conditions under which payment may be made under Part B for services rendered to patients by supervising physicians in the teaching setting and the method for determining the reasonable charge which may be recognized for such services. The enclosed guidelines are intended to clarify and supplement the criteria that govern reimbursement in this area as reflected in §§6102.7, 6335, and 6720 ff. of the Part B Intermediary Manual.

Carriers are urged to review their present reimbursement practices in light of these guidelines and to take appropriate action as soon as possible to bring practices into conformity with the guidelines. The Part B Intermediary Manual will be revised to incorporate these clarifications and additions.

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure

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Part 3 Payments for Services of
Supervising Physicians in a Teaching Setting

A. Conditions Which Must be Met for a Teaching Physician to be Eligible for Part B Reimbursement as an Attending Physician

The physician* must be the patient's "attending physician." This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

1. To be the "attending physician" for an entire period of hospital care, the teaching physician must as a minimum:

   a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

   b. personally examine the patient; and

   c. confirm or revise the diagnosis and determine the course of treatment to be followed; and

   d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and

   e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and

*The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident since the senior year of the residency is essential to completion of the program.

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f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

EXAMPLE: A supervising physician carried out all of the activities listed above for a surgical patient but (e). He was not present in the OR when the major surgery was performed because supervision of the 5th-year resident performing the operation was not required. A physician's charge would not be recognized for the surgical procedure because criterion (e) was not met. Therefore, the physician would not be an attending physician for the period of hospital care although he might meet the criteria listed in A.2. below and be held as the attending physician for a portion of the care provided.

Even if the supervising physician chose to be present in the OR, payment could not be made to him for the surgical procedure since his presence was not medically necessary and he could not, therefore, function as the attending physician in connection with the surgery. However, if he was scrubbed and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role (see item A.2. below).

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

EXAMPLE: A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patient's attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

2. A teaching physician may be held to be the attending physician for a portion of a patient's hospital stay: if the portion is a distinct segment of the patient's course of treatment (e.g., the pre-operative or post-operative period) and of sufficient

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duration to impose on the physician a substantial responsibility for the continuity of the patient's care; if the physician, as a minimum, performs all of the activities described above with respect to that portion of the stay; and if the physician is recognized as the patient's physician fully responsible for that part of the stay. If a teaching physician is not found to be the attending physician with respect to a portion of a patient's stay, he may not be reimbursed for any service provided to the patient for that portion of the stay unless it is an identifiable service that he personally rendered to the patient.

EXAMPLE: A physician carried out all of the activities listed above for a surgical patient until midway in the post-operative period, when the physician's teaching tour of duty ended. Since he was not responsible for the continuing care of the patient throughout the post-operative period, he cannot be reimbursed as the attending physician for that period.

3. Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.

4. The services of a teaching physician while visiting patients during grand rounds is basically teaching and does not contribute to an "attending" relationship with any of the patients visited.

5. An emergency-room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff. It is only through his direct personal involvement with a patient that a charge may be recognized under Part B. Such an involvement would necessarily include personal examination of the patient as well as direction of and responsibility for the treatment provided.

B. Determining the Amount Payable Under Part B

1. The amount paid for direct medical services rendered by the teaching physician should be related to only that discrete portion of the patient's care for which the physician exercised the pertinent responsibilities of an attending physician outlined in A.1. For example, if the patient's personal physician furnishes services before the hospital admission and after the discharge and the teaching physician becomes the attending physician only with respect to the inpatient care, the lesser extent of the teaching physician's service should be taken into account in recognizing a charge; otherwise the out-of-hospital service would be billed for and paid twice. Similarly, if surgery was performed and the teaching physician rendered identifiable personal service to the patient in the operating

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room, it is necessary to determine whether that physician performed services more nearly analogous to a consultant, an assistant at surgery (see first "Example" in part A), or as the "attending" surgeon in order to identify the appropriate reasonable charge. If the physician acted as the attending surgeon but did not render the pre- or post-surgical services generally performed by a private surgeon to a private patient, the difference in service should be reflected in the amount of reimbursement.

2. The following conditions should be taken into account in determining the "customary" charges of teaching physicians for services which they provide as attending physicians to Medicare beneficiaries.

   a. If the teaching physician has a substantial practice outside the teaching setting (i.e., more than half of the time spent in the practice of medicine is spent caring for people who were his patients before they were hospitalized or who were referred to him by physicians responsible for their care outside the hospital setting), his "customary" charges for services in the teaching setting will be related to the amounts he charges for similar services in his outside practice. Where the services performed in the teaching setting differ from those in the outside practice, reductions should be made for the lesser scope of services provided, time spent, visits or responsibility as an attending physician (not counting supervisory acts as time or visits).

   b. If the teaching physician does not have a substantial practice outside the teaching setting and the provider has established one or more schedules of charges which are collected for medical and surgical services furnished to a majority of non-Medicare teaching patients, his charges should be related to the provider's schedule of charges which are most frequently collected.

   EXAMPLE: A hospital with an approved teaching program receives payment for physicians' services rendered to 80 percent of its non-Medicare patients. Fifty percent are paid for by public assistance under a relatively low payment schedule; 20 percent are covered under a Blue Shield Plan with a somewhat higher fee schedule and the balances are covered under commercial plans. Since collections are made for a majority of patients and the most frequently used schedule of payment is the welfare schedule, the welfare schedule of charges should serve as the basis for determining the teaching physicians' customary charges for Medicare.

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c. Where neither the physician nor the provider has established charges for the physician's services which are in effect for non-Medicare patients, the carrier and intermediary must make the necessary charge and cost determination based on that portion of the physician's compensation which is for services to patients, determined pursuant to the regulations governing reimbursement for the services of provider-based physicians.

3. Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his reasonable charge for the services involved.

4. In determining the number of visits which may be considered reasonable, e.g., in a course of treatment for which a global fee is not ordinarily charged, the total number of visits which would have been made to the patient in a nonteaching setting should be used as a guide; visits in excess of this number are presumed to be primarily for teaching purposes. Similarly, total reasonable charges for a course of treatment in the teaching setting should be compared with and should not exceed the charges that would be expected in nonteaching settings for similar services. Also, the charges billed for an hour of a teaching physician's services should not exceed the amount of fees the physician generally receives for an hour's work in caring for nonteaching patients.

5. Where payment is made under Part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the same service as a teaching service. Part A payments to the hospital should therefore not be based on the total compensation of the physician if that compensation is in part for patient care. The total compensation should be reduced by the portion paid for patient care in accordance with the applicable provisions of the principles of reimbursement for services of hospital-based physicians to arrive at the hospital cost portion. Allocation of compensation received between both parts of the program should be in accordance with how the physician's time is actually spent. If a physician's only compensation for services in a teaching setting are paid by the hospital and the agreement states that only the supervisory, and not patient care, services are compensated, it is necessary to look behind the words of the agreement by reviewing the physician's actual obligations and activities and determining whether the compensation level is

reasonable for the supervisory and teaching services alone - and insufficient to cover patient care services as well. The carrier and intermediary should make this finding jointly.

EXAMPLE: An employment agreement between a physician and the hospital states that he will be paid $50,000 a year for administration, supervision and teaching. However, he spends one-half of his time in providing patient care. The carrier and intermediary determined that if his compensation were allocated solely to the time the physician spent in the performance of his hospital duties, it would yield an hourly rate of compensation about double the rate paid for similar work elsewhere in the area. Therefore, the carrier and intermediary concluded that only a portion of the compensation was for hospital activities and reimbursable under Part A. Since charges were not customarily billed for the medical services the physician provided, the remainder would serve as a basis for computing the physician's reasonable charges for patient care in accordance with B.2.b. above.

C. Carrier Responsibilities for Claims Review and Verification

1. The carrier is responsible for assuring that the bills being submitted were prepared with an understanding of the conditions governing payment for physicians' services in the teaching setting.

   To help carry out this responsibility, carriers will not pay bills (SSA-1490 or SSA-1554) for services rendered in the teaching setting in any month after May 1969, unless:

   a. the chief of the department or service involved certifies on a form furnished by the carrier that each of the billed services for that month meets the pertinent requirements of A.1., and A.2.; or

   b. the bill has been signed by the attending physician and he understands that he is certifying that he met the requirements for those services for which the claim is made.

2. The provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart. The carrier is expected as part of its responsibilities to make appropriate checks of patient records, examining admission, progress, and discharge notes to verify that services for which charges are billed met the appropriate coverage criteria. If the carrier

review shows that a significant portion of the services in the sample do not meet the criteria, appropriate steps should be taken to adjust the reimbursement.

3. Bills must indicate when services are furnished in the teaching setting, the name of the provider and attending physician involved, and the extent of the services provided as an attending physician. The services must be defined and quantified to avoid errors in applying the reasonable charge limitation—e.g., to avoid applying the reasonable charge for a global service where only the surgical procedure or another component service was provided as an attending physician.

4. The carrier will need to carry out the steps necessary to assure itself that these conditions set out in B.1. are met—for example, to assure itself that any schedule of charges proposed for the teaching setting is actually applied and collected.

D. Who May Bill

Where the supervising physician is a member of a group which provides teaching services in a hospital, the Part B payment for services rendered as attending physicians by the group may be billed for:

1. by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients) on form 1490;

2. by the hospital on form 1554 provided that the carrier has determined that the certification described in C.1.a. has been executed and complied with; and

3. if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school on form 1490.

The individual physician's authorization is required to be on file in writing with the hospital or other organization to permit any of the above organizations to bill on his behalf. The organization must furnish to the Part B carrier the names of the physicians who have authorized the organization to bill on their behalf, and must agree to keep the carrier informed on a current basis of changes in membership in the group.

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 19 1985

Richard L. Fogel
Director, Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary has asked that I respond to your request of November 20 for our comments on your draft report entitled, "Documentation Problems Continue for Medicare Services Provided by Teaching Physicians." We have carefully reviewed your report and have no comments.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

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